Resistance during psychotherapy

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The purpose of the present study into the phenomenon of resistance was twofold. First, the meaning of the concept as conceived by therapists of psychoanalytic and behavioral orientation was investigated. Second, an attempt was made to gain insight into the dynamics of the clinical phenomenon of resistance. The results of the study indicated that both groups of therapists attached virtually the same meaning to the concept of resistance. Both groups viewed the same classes of behaviors as indicative of resistance. Furthermore, it was found, as expected, that analytically oriented therapists reported the occurrence of resistance more frequently. The two groups agreed that "avoiding" and "fighting" behaviors were the most prominent resistances of clients. Therapist behaviors that were most likely to elicit resistance in the client are the "informative" behaviors, such as asking questions about the nature and origin of the complaint. Clinical implications of the research findings are discussed.

Resistance During Psychotherapy and Behavior Therapy

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A substantial number of psychotherapies prove to be unsuccessful (Foa & Emmelkamp, 1983; Wachtel, 1982). In theorizing about the causes of these failures, the concept of resistance is increasingly used (e.g., Goldfried, 1982; Langs, 1981; Strean, 1986; Wachtel, 1982). This tendency can be observed in the two theoretical orientations in which most publications on the subject can be found; that is, in writings of psychoanalytically and behaviorally oriented therapists (see De Moor, 1982; Goldfried, 1982; Wachtel, 1982). In personal communications with the principal investigator, leading theoreticians in the field of therapy, such as Skinner (personal communication, September 26, 1985), the late Carl Rogers (personal communication, October 23, 1985), Ellis (personal communication, October 20, 1985) and Lazarus (personal communication, September 5, 1985; see also

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Lazarus & Fay, 1982), all denied the clinical significance of the concept. Yet, the concept of resistance is still widely used and is indeed getting more and more attention recently, as is demonstrated by the growing number of books on the subject.

The first theory of resistance was developed by Freud. Initially, Freud (Freud & Breuer, 1895/1974) considered resistance as an obstacle to the progress of therapy. Later on Freud came to view resistance as one of the *cornerstones* of psychoanalytic theory (Freud, 1923/1961). This view was elaborated in his *Inhibitions, Symptoms and Anxiety* (Freud, 1926/1979), in which he introduced a distinction between five different kinds of resistance, stemming from three different sources (i.e., the ego, id, and superego). One of the characteristic features of Freud's approach is the lack of a clear link between resistance and overt behavior. Virtually any behavior can be a sign of resistance depending upon the context of occurrence (see Freud, 1926/1979). This has implications for research on the subject. If the occurrence of resistance can only be inferred within a particular context, empirical studies on the subject should include systematic descriptions of both clients' behaviors and therapeutic situations (see Auld & White, 1959). Remarkably, no such studies have been reported in the literature.

Psychoanalytically and behaviorally oriented therapists think in different ways about the causes of resistance. Most psychoanalysts consider resistance to be caused mainly by the client. For most behavior therapists, on the other hand, resistance can be and often is induced by the therapist: The occurrence of resistance is a consequence of the therapist using a wrong method or using a right method at the wrong time (Goldfried, 1982; Lazarus & Fay, 1982).

There appears to be more agreement in the literature as to which behaviors characterize resistance. For most behavior therapists, resistance is shown by the client not following instructions or not completing his or her homework assignments (Goldfried, 1982; Hersen, personal communication, March 6, 1989). Or as Turkat and Meyer (1982) state: "Resistance is client behavior that the therapist labels anti-therapeutic" (p. 168). In most analytic publications on resistance (for an extensive review of the literature on resistance, see Verhulst, 1987), there is an implicit conception of resistance as client behavior

that is not in line with the intentions of the therapist. For example, the client is silent, does not tell things, is angry, drops out of therapy, and so on.

In one of the few empirical investigations of resistance, Auld and White (1959) studied the temporal correlation of resistant sentences and silences. They found a positive correlation. In a similar study, Goldenberg and Auld (1964) found resistance to be equivalent to silence. Speisman (1962), investigating the relationship between resistance and depth interpretation, constructed a rating scale for the measurement of resistance. Noncooperative behaviors of the client (such as showing opposition, making superficial remarks, and "blocking") were taken to refer to resistance. Subjects in this study were three different judges, familiar with psychotherapy. Speisman (1962) concluded that the scale was "not satisfactory" (p. 392), because subjects did not agree as to what behaviors were indicative of resistance in the client. In another study, Shapiro (1972) asked 68 therapists to give a description of their most resistive client. Of the 25 therapists who responded, most indicated that they did not really know what was meant by "the most resistive client."

In a final study, Chamberlain, Patterson, Reid, Kavanagh, and Forgath (1984) developed a "Client Resistance Code" (CRC), a coding system to study resistance. Three well-trained observers were asked to code each verbalization of the client as either resistant or cooperative. Videotaped therapy sessions were used as stimulus material. In this study, too, resistance was operationalized as the occurrence of various noncooperative behaviors of the client (such as quarreling with or showing a negative attitude toward the therapist, not reacting, changing the subject and expressing doubt about the therapist's competence). Client responses that followed the direction set by the therapist were taken as an indication of the absence of resistance. The authors found "moderate support" (Chamberlain et al., 1984, p. 144) for the construct validity of the CRC.

All the studies have serious shortcomings. For instance, the concept of resistance was not clearly defined in most cases. Also, relatively little attention has been given to a systematic evaluation of the antecedent conditions of resistance: What was the behavior of the therapist just before the client showed resistance? How was the atmosphere of

the therapeutic setting when the resistance occurred? Furthermore, even though most authors agreed that both client and therapist variables should be taken into account, in none of the studies was there an attempt made to vary these factors independently and to evaluate their relative impact.

In the present study an effort is made to determine the meaning attached to the concept of resistance by psychotherapists of analytic and behavioral orientation. Also, antecedent conditions of resistance were systematically studied.

A stimulus-response inventory (SR-inventory) (see Furnham & Jaspars, 1983, for a recent evaluation of this technique) was used in the present study, because this allows for an estimation of the relative impact of the client's behavior and the therapist's intervention on the occurrence of resistance.

Two pilot studies were carried out in order to be able to construct a specially designed "resistance questionnaire." In the first pilot study, the aim was to get a description of the domain of resistance: What behaviors can be expected to occur within the context of resistance? Six male Dutch professors of psychology (three of each orientation, mean age, 54, and all of them with more than 20 years of clinical experience) were asked to generate examples of what they regarded as typical examples of resistance in clients. These professors were chosen as subjects in this study because they were outspoken exponents of the psychoanalytic and behavioral orientations. These subjects were asked to give detailed descriptions of the behaviors of the client, as well as of the behaviors of the therapist, just before the resistance occurred. They were also asked to give a detailed description of the situational context (the general atmosphere) in which the resistance occurred. The examples given by the six respondents, combined with the most frequently mentioned resistance behaviors in the literature, yielded a total of 57 verbs that were considered to cover most typical resistance behaviors. These verbs are presented in Table 1.

From a statistical point of view, the 57 verbs constitute an unwieldy set. Hence, the 57 verbs should be reduced to a smaller set which can be more easily managed from a statistical viewpoint. In a second pilot study, an attempt was made to reduce the 57 verbs of the first pilot study into a small number of semantically meaningful dimensions

TABLE 1

The Verbs and Their Three-dimensional MINISSA Configuration

Verb	*Dimension I*	*Dimension II*	*Dimension III*
losing attention	0.4232	–0.3602	–0.8197
touching	0.3844	–0.5657	0.4667
hesitating	0.4101	0.4561	–0.3508
changing the subject	0.3883	–0.2343	–0.8915
making an appointment	0.8094	0.6279	0.4363
rejecting	–0.4813	0.5983	–0.3944
accusing	–0.8613	–0.0458	–0.0911
admiring	1.0291	–0.1841	0.2681
making objections	–0.5074	0.4417	–0.1364
making compliments	1.1651	–0.2932	0.1786
approaching	0.7351	–0.1084	0.6191
discussing	–0.0550	0.5127	0.1503
driving	–0.3313	0.2968	0.6514
forcing	–0.4795	0.1772	0.7393
making a proposition	0.4666	0.7535	0.2663
making a joke	0.5221	–0.9349	–0.4870
agreeing	1.1223	0.3831	–0.2175
crying	–0.4030	–0.5952	–0.0309
consenting	1.0841	0.3937	0.0225
complaining	–0.8127	0.1392	–0.4002
getting angry	–0.6841	–0.1492	0.1303
criticizing	–0.3812	0.5078	0.0112
laughing	0.7735	–0.8919	–0.2665
deceiving	0.5135	–0.3285	–0.3740
thinking	0.3513	0.9202	–0.3980
not reacting	0.3140	0.2110	–1.0893
denying	–0.5484	0.4165	–0.8417
to agree with anything	1.3507	0.2183	–0.3930
talking over	0.4200	0.4250	0.8067
deliberating	0.4893	1.2134	0.1473
convincing	0.2558	0.6551	0.6924
talking nonsense	0.4364	–0.6302	–0.8523
persuading	0.1826	0.5183	0.7597
pestering	–0.4015	–0.9869	–0.1170
protesting	–0.7530	0.3051	0.0229
teasing	–0.1817	–1.0852	–0.1075
quarreling	–0.7068	–0.3361	0.1333
calling names	–0.8805	–0.4190	0.2252
shouting	–0.8576	–0.3573	0.4339
lighting up a cigarette	–0.2060	–0.2887	1.0233
seeking excuses	–0.0582	–0.3842	–0.8211
stamping with your feet	–1.0006	0.1250	0.4788
stuttering	–0.2247	–0.9695	0.4602
arguing	–0.7098	0.5175	0.1691

TABLE 1 Continued

Verb	*Dimension I*	*Dimension II*	*Dimension III*
trembling	–0.3275	–0.6401	0.6691
challenging	0.0475	–0.3244	0.6063
seducing	0.6951	–0.4900	0.5655
reproaching	–1.0435	–0.0748	–0.2160
courting	0.8102	–0.5263	0.4257
flattering	1.0469	–0.6420	0.1931
cursing	–1.1036	–0.1881	0.3410
asking questions	0.0400	0.9753	–0.0778
asking for explanation	–0.2352	0.9950	–0.1845
dropping out of therapy	–0.7321	–0.5344	–0.5558
refusing	–0.7084	0.6294	–0.4762
saying you do not understand	–0.1110	0.3831	–0.8350
whining	–0.4797	–0.2318	–0.6621

covering the same meaning. To that purpose a list of all 1,596 (= 57*56/2) combinations of the verbs was prepared. The list was presented to a group of student nurses (male and female, $N = 42$, ages between 19 and 24 years). The goal of this second pilot study was the investigation of the semantic structure of the verbs. Student nurses were chosen as subjects because they did not have a professional competence in clinical interventions. For each pair of verbs the student nurses were asked to indicate the degree of similarity in meaning of the two verbs on a five-point scale. It should be noted that in the test instruction no reference was made to the field of psychotherapy.

Euclidean distances between each pair of verbs, averaged over all subjects, were computed. The obtained distance matrix (between all pairs of verbs) was subjected to a MINISSA (Lingoes & Roskam, 1973), a multidimensional scaling procedure. Although the stress was high (0.18), a three-dimensional solution was chosen because this could be easily interpreted. This indicated that the meaning of the 57 verbs is quite accurately covered by three dimensions.

The three bipolar dimensions amounted to six clusters. The first cluster, the positive pole of the first dimension, referred to a positive attitude and a willingness to approach. Examples of verbs with high loadings are “admiring,” “approaching,” and “agreeing.” The second cluster, the negative pole of the first dimension, referred to a negative attitude. The verbs with extreme scores are dealing with conflicts such as “protesting,” “cursing,” and “arguing.” The third cluster, the posi-

tive pole of the second dimension, contained rational activities, such as "making a proposition," "deliberating," "thinking," and "asking." In cluster four, the negative pole of the second dimension, all verbs were expressions of emotionality, either positive (e.g., "laughing" and "making jokes") or negative ("crying" and "trembling"). The fifth cluster, the positive pole of the third dimension, contained verbs that initiate subsequent action such as "forcing," "convincing," and "persuading." The sixth cluster, the negative pole of the third dimension, was characterized by a set of "evasive" actions, such as "losing attention," "avoiding," "talking nonsense," and "denying."

It is interesting to compare the present results with the work of Schank and Abelson (1977). These authors made a distinction in six different "delta-goals" or "d-goals," as they are called. On the basis of an extensive analysis of our everyday language, these authors postulated a limited number of basic categories of behavior, the "primitive actions," as they are called. Most verbs can be placed in one of these categories of primitive actions. Furthermore, in each verb some kind of intentionality is represented. This intentionality is called a d-goal. The six d-goals are d-social control (the intention to gain power or authority), d-control (the intention to gain control over physical objects), d-proximity (the intention to move to a new location or to another person, to seek contacts), d-know (the intention to increase one's knowledge), d-agency (the intention to get someone else to pursue a goal on one's own behalf), and i-preparation or i-prep (in this category all verbs with an "action-preparing" nature are taken together, such as "making appointments" and "making propositions").

When comparing Schank and Abelson's (1977) taxonomy with the present six clusters, remarkable similarities can be found. The first cluster with verbs such as "admiring," "making compliments," and "flattering" has a strong resemblance to d-proximity. The second cluster, which is characterized by verbs such as "cursing" and "quarreling," is similar to d-social control. The third cluster shows characteristics of d-know and i-prep. Both categorizations include such verbs as "thinking," "deliberating," "asking questions." The fourth cluster does not have an equivalent in the system developed by Schank and Abelson (1977); these authors do not have a separate category of emotional behaviors. The fifth cluster, with verbs such as "forcing,"

"persuading," and "convincing," is similar to d-agency. The sixth cluster, consisting of "evasive" actions, also does not have a pendant in the d-goal system. In sum, four out of six clusters are more or less equivalent to concepts in Schank and Abelson's (1977) taxonomy.

Previously it was argued that resistance should be studied in a particular context; also, attention should be paid to its antecedent conditions. Therefore, two aspects of the therapeutic situation were varied systematically in the present study; namely the general context of the therapy and the interventions of the therapist that precede the resistance behavior of the client.

METHOD

A total of 170 Dutch psychotherapists (85 behaviorally and 85 analytically oriented) were asked to participate in the study. In all, 82 of the analytically oriented therapists were male; 59 of the behavioral therapists were male. The analytic therapists had an average of 17.2 years of clinical experience; the behavior therapists, 12.9 years. The mean age of analytical respondents was 44 years; for the behavior therapists the mean was 41.

A total of 44 questionnaires (22 from analysts and 22 from behavior therapists) were returned. No systematic differences between responders and nonresponders were found with regard to sex, theoretical orientation, or years of experience.

The questionnaire was presented as an SR-inventory. Each stimulus situation of the SR-inventory, that is, each page of the test booklet, consisted of four elements:

1. *A short description of the case, giving some general information.* The age, gender, and major complaint of the client were described. Six different cases were chosen out of the 18 examples of resistance that were generated by the subjects of the first pilot study. Examples were chosen on the basis of the fact that they represented a specific delta-goal activity. Three examples of psychoanalysts and three examples of behavior therapists were chosen.
2. *A description of the therapeutic context in which the therapy session took place.* This context was presented in the questionnaire as a "fragment of a session." The contexts were derived from the examples

generated in the first pilot study. Because Schank and Abelson's (1977) delta goals provide a widely applicable taxonomy of goal directed behaviors, they are used here to distinguish various therapeutic contexts. Thus six contexts were chosen, each representing a different d-goal. In some instances, a context was slightly rewritten as to make the particular d-goal character more pronounced. The first context had a d-control nature. Characteristic behaviors were "convincing" and "agreeing." In the second context, d-know was represented, for example, "asking questions." The third context refers to proximity. Typical actions are "coming closer," "approaching" and "making compliments." The fourth context represented i-preparation. Actions such as "preparing," "thinking" and "planning" were predominant here. In the fifth context, d-social-control was represented. Characteristic behaviors are "accusing," "quarreling," "fighting" and "swearing." The sixth context was of a d-agency nature. Actions such as "persuading" and "forcing" could be found here.

3. *A description of the "trigger."* By this is meant the intervention of the therapist who elicits the behavior in the client that can be viewed as a manifestation of resistance. The different triggers were derived from the examples generated by the subjects of the first pilot study. Each trigger had a different d-goal character. For example, when the therapist tried to convince the client, this was seen as a d-control trigger. The six descriptions of the background information were crossed with the six interventions of the therapist, thereby yielding 36 descriptions of therapeutic situations. In the test booklet, a single description of the background information was presented six times, one after the other, each time followed by a different intervention of the therapist. The order of the interventions was randomized across the general descriptions (the background information).
4. *The list of 57 verbs of the first pilot study (the "responses" of the SR-inventory).* The list of verbs was presented just below each stimulus situation. Subjects were instructed to read carefully each of the 36 descriptions of therapeutic sessions, giving special attention to the last underlined sentence of each situation in which the intervention of the therapist was described. After reading this, subjects were asked to imagine that the client showed each of the 57 behaviors that were printed under the intervention of the therapist. After each verb a five-point scale was presented on which the subject could indicate to what degree the particular behavior referred to resistance in his or her opinion.

In addition to the SR-inventory, some biographical questions were asked (age, sex, and number of years of experience). Finally, the

therapists were asked to indicate whether or not they considered resistance a suitable concept in therapeutic practice.

In a preliminary analysis, a MINISSA procedure (Lingoes & Roskam, 1973) was applied to the data of the two groups of therapists together. Correlations between the scores averaged over the 36 stimulus situations on the verbs were the distance measure. The solution obtained was virtually identical to the configuration obtained in the second pilot study.

An analysis of variance was used to answer the major research questions. The independent variables in the analysis were groups (2 levels), subjects (2 × 22 levels, nested in groups) contexts (6 levels), triggers (6 levels), and clusters (6 levels). The latter corresponded to the clusters that were found in the study with the student nurses. The dependent variable was the resistance score. Rather than using the 57 scores at the separate verbs, six cluster scores were computed for each of the 36 stimulus situations. In the computation of the cluster scores the configuration of the second pilot study was used. For each cluster a set of verbs was selected with absolute MINISSA loadings higher than 0.70 on the cluster. These loadings were used as weights in the present study. The cluster scores were obtained by multiplying the therapist's score at a selected verb with the cluster weight of the previous study; this was then divided by the number of items in the cluster.

RESULTS

All psychoanalytical subjects (100%) and 19 out of 22 subjects of the behavioral orientation (86%) found the concept of resistance a useful one. All subjects (minus three behavior therapists) considered resistance a phenomenon that occurs in every therapy.

The results of the analysis of variance are presented in Table 2. The main effect of groups was found to be significant ($F = 8.58$; $df = 1,42$; $p < .01$). Apparently, analysts and behavior therapists did differ in the degree to which they regarded behaviors of clients as referring to resistance. The average score of the analysts was significantly higher

TABLE 2
Results of the Analysis of Variance and the Estimated Variance Components ($\hat{\sigma}^2$)

Source	*df*	*Mean Squares*	*F*	*Prob.*	$\hat{\sigma}^2$
Group (G)	1	482.42	8.58	.01	.0897
Context (S)	5	2.86	1.79	.12	.0008
Triggers (T)	5	3.76	5.53	.00	.0019
Clusters (C)	5	651.88	115.80	.00	.4080
Subjects (P)	42	56.23			.2604
GS	5	1.30	.81	.54	.0000
GT	5	.78	1.14	.34	.0001
GC	5	4.07	.72	.61	.0000
ST	25	.96	2.99	.00	.0024
SC	25	.64	1.87	.01	.0011
TC	25	1.58	1.77	.00	.0054
PS(G)	210	1.60			.0444
PT(G)	210	.68			.0189
PC(G)	210	5.63			.1564
GST	25	.24	.76	.80	.0000
GSC	25	.33	.98	.50	.0000
GTC	25	.10	.69	.87	.0000
STC	125	.23	2.63	.00	.0032
PST(G)	1050	.32			.0538
PSC(G)	1050	.34			.0565
PTC(G)	1050	.15			.0245
GSTC	125	.08	.95	.65	.0000
PSTC(G)	5250	.09			.0867

NOTE: Negative estimated components were set at zero.

(2.66 versus 2.21), indicating that analysts were more likely to regard certain behaviors as referring to resistance.

It could be argued that this significant effect covered substantial intergroup differences in the meaning attached to the concept of resistance. In order to investigate this, the scores of all 22 subjects in a group over all 36 stimulus situations were averaged, thereby producing two vectors of 57 verbs, (one for each group). Spearman's ρ between these vectors turned out to be highly significant ($\rho = .93$, $p < .001$). This result would have been highly unlikely when the concept of resistance was viewed in different ways in the two groups of therapists.

The main effect of triggers also yielded a significant value ($F = 5.53$; $df = 5,210$; $p < .001$). Some triggers (i.e., interventions of the

therapist) were more likely to elicit resistance than other ones. In post hoc tests it was found that the d-know trigger ("asking questions") induced resistance most frequently. The least resistance was induced by the d-prox trigger ("being friendly and nice") and, remarkably, by the social control trigger ("quarreling," "fighting"). This pattern of findings indicated that problem-oriented rather than emotion-oriented interventions of the therapist tended to trigger resistance in the client.

The main effect of clusters (i.e., client's behavior) was also significant ($F = 115.80$; $df = 5,210$; $p < .001$). Not unexpectedly, the second cluster (similar to d-social control) with verbs such as "shouting," "fighting," "yelling," and "quarreling" was considered to be most characteristic of resistance. The sixth cluster containing evasive actions, such as "losing attention" and "changing the subject," also revealed high scores. The lowest scores were obtained for the first cluster ("making compliments," "agreeing," and "admiring") and the third cluster (rational activities such as "thinking" and "asking for an explanation").

The pattern of significance of the interactions was clear cut. All interactions were significant—and fairly large in terms of their estimated components of variance (see Table 2)—unless group was included. This means that the occurrence of resistance did not depend only upon the behavior of the therapist or of the client but upon the interaction of these components. To what degree the behavior of a client was considered an indication of resistance also depended upon the specific context in which it occurred. Furthermore, this view was commonly held by both groups of therapists, again underlying the communality in meaning of the concept in the groups.

As an evaluation of the relative size of the factors, estimated components of variance are presented in Table 2. It can be seen in the table that the components dealing with subjects were large compared to the other variance components. Particularly, the main effect of persons and the person by cluster interaction were large. The former indicated that there are consistent individual differences in the activities (clusters) associated with resistance. The latter pointed to the existence of consistent individual differences in the way in which clusters are taken to reflect resistance in a particular situation.

In a final analysis, the relationship was investigated between various characteristics of the therapists and their judgment of resistance. This was done in a multiple regression analysis with the therapist's sex, his or her theoretical orientation (analytical versus behavioral), years of experience, and some attitudinal questions as the independent variables. The latter involved the suitability of the concept of resistance (scored dichotomously), the frequency of occurrence of resistance (scored dichotomously as either or not occurring in each therapy), and the question as to whether resistance was related to the therapist, the client, or both. The dependent variable was the resistance score, averaged over all responses. The squared multiple correlation was .23, which was not significant. The only significant predictor was the therapist's orientation, which replicated the findings of the analysis of variance. Thus the judged occurrence of resistance appeared to be unrelated to any other therapist characteristic than his or her theoretical orientation.

DISCUSSION

In the present study evidence was found for the usefulness of the concept of resistance in clinical practice. The striking absence of any interaction between theoretical orientation and any other independent variable in the analysis of variance indicated that both groups attach the same meaning to the concept of resistance. This implies that therapists of analytical and behavioral orientation think of the same classes of behavior when referring to resistance. According to most therapists, resistance can be observed in almost any therapy. Furthermore, the judgment of therapists about resistance was fairly systematic. Various factors were found to influence judgment: the behavior of both the client and the therapist, the situation that gave rise to the resistance, and interactions between these factors. This was found for both analysts and behavior therapists. This points to the usefulness of the concept of resistance: It summarizes an interrelated set of behaviors that can be recognized by all therapists. The only difference between the two groups of therapists was found in their overall mean; the average score of behavior therapists was somewhat lower. This

presumably reflects the theoretically inspired reluctance of behavior therapists to use the concept.

There were large individual differences in the meaning therapists attached to the concept. Some therapists tended to associate particular behavior more often with resistance than did others. These individual differences were found within each theoretical orientation and were much larger than were the overall differences between analysts and behavior therapists. Also, it was found that not each client behavior was equally likely to be considered a sign of resistance. This concurs with previous findings (Auld & White, 1959; Chamberlain et al., 1984; Goldenberg & Auld, 1964), but contrasts with remarks made by numerous others (e.g., Freud, 1926/1979; Greenson, 1968; Sandler, Dare & Holder, 1973). In the present study it was found that interventions of the therapist with a d-know character were most likely to elicit resistance. This finding is in accordance with observations that most clients do not like to talk about their problems (Greenson, 1968; Sandler et al., 1973). The analogy with Freud's "repression resistance" (Freud, 1926/1979) and the behavior therapeutic "avoidance behavior" is obvious: Clients try to escape from painful subjects or memories. Both analytic and behavior therapists, however, focus their attention on these (memories of) painful events. It could be argued that resistance often comes down to a conflict between client and therapist; both want to go in different directions. The observation that the client's behavior with the highest resistance score was d-social control is in line with this argument. Rather unexpectedly, it was found that therapist interventions with a social-control character do not evoke resistance. The reason for this finding can be the fact that the respondents of the main study did not find the stimulus situation very realistic, because it implies a violation of the widely held norm that a therapist should not quarrel with a client. When a client becomes angry with the therapist, following d-social control behavior of the therapist, this behavior will not be taken to refer to resistance, but may be considered a fairly legitimate refusal to cooperate (see Ellis, 1985; Lazarus & Fay, 1982).

As to the clinical implications of the research findings, the following suggestions can be made. The often strong disagreements among writers of different theoretical backgrounds on the concepts of resis-

tance were absent in our data. For both behaviorally and psychoanalytically oriented therapists there is an identical set of interrelated client behaviors, which is described here as resistance. Whether this is the best term for the concept is immaterial. More important, the set of behaviors reflects an easily recognizable therapeutic phenomenon that commonly occurs. Also, behavior therapists argue that resistance behavior is most likely to occur at the phase of therapy in which the client has to show new behaviors that he or she has learned in the therapy (Lazarus & Fay, 1982). Our research findings suggest, however, that resistance is most likely to occur in the phase of therapy in which the therapist is asking the client for information. This gathering of information usually takes place at the beginning of the therapy; hence, this is where resistance can be expected to occur. So, contrary to what behavior therapists expect, resistance will occur at the onset of a therapy. It can be a mistake to consider all "negative" behavior (i.e., noncooperative acts of the client) as an expression of "stubbornness" (Ellis, personal communication, October 20, 1985) or as a sign of "non-compliance," as Lazarus (personal communication, September 5, 1985) does. Rather, from a theoretical point of view, it might be more adequate to view these behaviors as indications that the core of the client's problem is approached. This finding is in line with Freud's remark that resistance behavior points out the direction a therapy should take (Freud, 1933/1972).

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